

Review article

Interventions to improve therapeutic communications between Black and minority ethnic patients and professionals in psychiatric services: systematic review

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Background

Communication may be an influential determinant of inequality of access to, engagement with and benefit from psychiatric services.

Aims

To review the evidence on interventions designed to improve therapeutic communications between Black and minority ethnic patients and clinicians who provide care in psychiatric services.

Method

Systematic review and evidence synthesis (PROSPERO registration: CRD42011001661). Data sources included the published and the 'grey' literature. A survey of experts and a consultation with patients and carers all contributed to the evidence synthesis, interpretation and recommendations.

Results

Twenty-one studies were included in our analysis. The trials showed benefits mainly for depressive symptoms, experiences of care, knowledge, stigma, adherence to prescribed medication, insight and alliance. The effect sizes were smaller for better-quality trials (range of d 0.18–0.75)

than for moderate- or lower-quality studies (range of d 0.18–4.3). The review found only two studies offering weak economic evidence.

Conclusions

Culturally adapted psychotherapies, and ethnographic and motivational assessment leading to psychotherapies were effective and favoured by patients and carers. Further trials are needed from outside of the UK and USA, as are economic evaluations and studies of routine psychiatric care practices.

Declaration of interest

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Research highlights persistent inequalities in both experiences and outcomes for people from minority ethnic groups when compared with White British patients in contact with psychiatric services.^{1,2} There is a lack of engagement, poorer access to effective services and psychological interventions, more conflict between patients and staff, fears about reliance on emergency contacts with the police and the criminal justice system, and ethnic variations in the use of drug treatments.^{3–5} The overrepresentation of specific ethnic groups in specialist psychiatric care contrasts with lower use of primary care and public health interventions.^{1,2} These findings are mirrored in the USA, Canada, Australia and other European countries. One explanation for these inequalities is that the quality of therapeutic communication between patient and practitioner is poorer for minority ethnic groups. Therapeutic communication refers to any conversation (face-to-face or technology-assisted) that seeks to improve therapeutic outcomes through understanding and engagement. For example, communications can provide information to deal with uncertainty or reassurance and changes to the care to remedy dissatisfaction. Communications about diagnosis and assessment questions can also be helpful for patients who may fear what is happening and that no one can help. Therapeutic communications can also include discussion of treatment expectations, showing understanding and empathy as well as psychological interventions that rely on conversation and challenging cognitive bias. A stronger therapeutic alliance is one process through which good

communication can lead to improved outcomes for patients.⁶ Effective communication is central to psychiatric assessment, diagnosis, treatment adherence and recovery.^{7,8} Dissatisfaction among immigrants and ethnic minorities can emerge if there are cultural differences in expectations and health beliefs (also called explanatory models) between the patient and professional.^{9,10} For example, non-biological explanatory models for mental illness are associated with poorer therapeutic relationships and greater dissatisfaction.¹¹ In such circumstances professionals struggle to empathise, assess the patient's emotions^{12–16} and understand symbolic and metaphorical idioms of distress and these can compromise clinical decisions and accurate diagnosis, and lead to disengagement.^{7,11, 17–19}

These findings have led to calls for cultural competence in communications during clinical assessment, diagnosis and treatment.^{20,21} One approach to improve cultural competence is to explore patients' narratives about their illness during the assessment and use these to culturally adapt interventions.^{22–24} For example, adaptation can involve practical changes to the venue or the sequence in which components of an intervention are provided in order to improve access and uptake; other changes include modifications of the content of written materials and interventions in terms of language or metaphors, the philosophical aims of the treatment (tolerance or cure or recovery) can be renegotiated; and the proposed theories, often shared with the patient, of how the intervention works may need to be discussed

and modified as more research evidence emerges.^{24,25} So, interventions targeting therapeutic communications may reduce inequalities of experiences and outcomes from psychiatric care. Although many systematic reviews of devices or technologies seek out a single intervention and a single context, in this review we synthesise diverse types of evidence on the effectiveness of interventions designed to improve ‘therapeutic communication’ between Black and minority ethnic (BME) patients receiving specialist psychiatric care and the professionals who deliver that care (the THERACOM project). We identify and describe the elements of effective interventions and assess evidence from quantitative randomised and non-randomised trials as well as qualitative studies that help us understand what is an effective intervention.

Method

This paper is an accessible evidence summary of a National Institute for Health Research funded study; the full protocol and PROSPERO registration details are in the public domain (PROSPERO: CRD42011001661).²⁶

Inclusion and exclusion criteria

Eligible studies included all age groups and all ethnic groups known to be prominent in healthcare settings in the UK: people from Indian, Pakistani, Bangladeshi, Sri Lankan, Black Caribbean, Black British, Black African, Irish and Chinese backgrounds (see online supplement DS1). We included all evaluative methodologies. We amended the original protocol to include studies on diaspora and interventions judged to be of relevance to the UK. We excluded studies on interventions that were considered to be generic therapeutic communications themselves, such as psychological therapies or music therapies, rather than interventions that adapted and improved practice. For example, we looked for evidence of the elements of cultural adaptation recommended by Tseng, including philosophical, technical, theoretical or practical adaptations.²⁵ We excluded studies of translation or interpretation as there is already a strong evidence base.^{27,28}

Search strategy

An information scientist and a researcher jointly developed, iteratively tested and refined the search strategy to capture known seminal papers. The final search strategy was agreed following further discussion with all investigators, user and carer representatives (online supplement DS2). Separate data sources and search strategies were developed for distinct sources: published papers, grey literature, websites, special collections and theses. Experts were invited to comment on omissions in the searches and to put forward candidate papers and to volunteer research work that was unpublished or in progress. Community groups and charities were also contacted to identify materials in community-based collections. The search terms from previous reviews were adapted to reflect specific ethnic groups,^{21,29–31} and for different aspects of therapeutic communication, types of mental disorder, professional groups and measures of clinical outcome.

Selecting appropriate sources

Citations were downloaded into an Endnote library. Their relevance was assessed against the predetermined inclusion and exclusion criteria (online supplement DS1) by two researchers who independently screened all titles and abstracts. Forward and

backward citation tracking complemented the database searches. Full-text manuscripts were obtained for all studies entering the review. Any uncertainties about entering the review were resolved by consensus and, if necessary, by a third reviewer and examination of the full text.

The database searches yielded 7329 hits of which 3733 records were screened as potentially relevant after removing duplicates (Fig. 1). An extensive search for grey literature yielded 608 sources.

Quality assessment

To score methodological quality we used some core criteria for all papers, irrespective of study design, augmented by design-specific criteria (online supplement DS3).^{32–36} The scores for each element were summed to produce a total score, and then presented as percentages of the maximum score (for each of the items and the total overall quality score) (Table 1). These were then categorised into low, medium or high quality on the basis of percentage of the maximum score: <33% low, 33–66% medium and >66% high.

Data extraction, analysis and synthesis

Two reviewers extracted data directly to an Excel spreadsheet. Randomised trials provide the most definitive evidence of effectiveness.³⁷ Therefore, we separately report randomised controlled trials (RCTs) and non-randomised designs: comparative observational studies, case series, qualitative studies or qualitative elements of other studies and case studies. We contrasted narrative outcomes, effectiveness, and design strengths and weaknesses across the studies. Wherever possible for important quantitative findings, we give the measures of effect presented in the original publications (reported effects), and in the absence of such measures; wherever possible, we calculated the standardised mean difference ‘*d*’ and 95% confidence interval (calculated effects) from the published data. Calculations used the Campbell collaboration online calculator (http://www.campbellcollaboration.org/resources/effect_size_input.php).

Owing to the diversity of study settings, interventions and outcomes, the data were not suited to meta-analyses or meta-regressions. Instead, the results were subjected to a narrative synthesis that included four elements:³⁸ textual description, tabulation, grouping and thematic analysis. The effective components of each intervention were identified during the thematic analysis. As part of this analysis, we classified how interventions were culturally adapted using the framework originally proposed by Tseng.²⁵

Patients’ and carers’ views

We worked with the Afiya Trust, who recruited a panel of mental health service users and carers with experience of similar research, and from both genders, and diverse ethnic and religious groups. In three workshops, panel members discussed their perspectives on therapeutic communication, and then they commented on and ranked the interventions identified in the review as high or low priority. These judgements informed the synthesis and recommendations.

Results

In total, 21 publications met the inclusion criteria and were included in the review (online Tables DS1–4 give details of samples, settings, methods and findings). These included 12 randomised trials,^{39–50} 1 of which was from the grey literature;⁵⁰

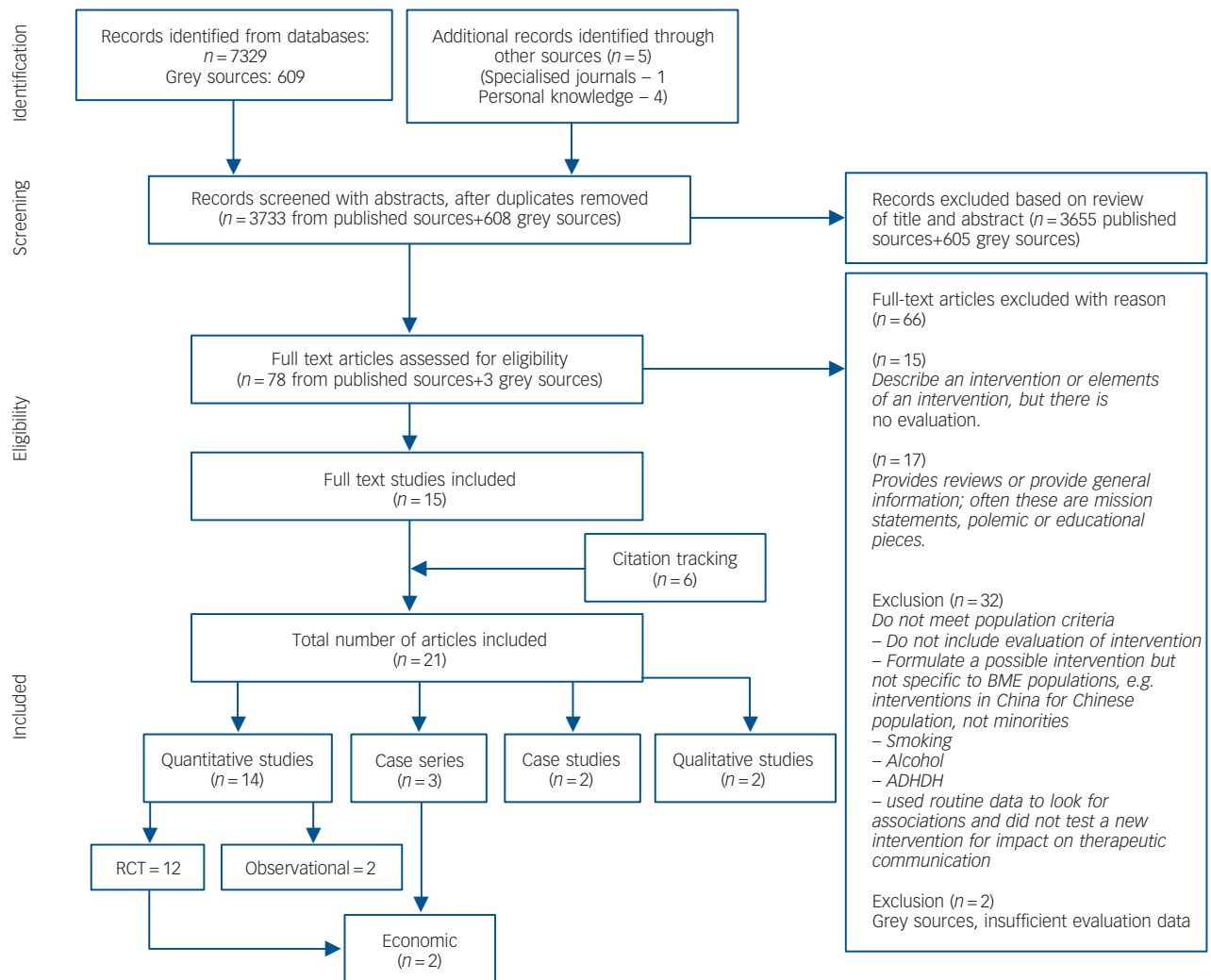


Fig. 1 PRISMA diagram showing selection of papers at each stage.

BME, Black and minority ethnic; ADHD, attention-deficit hyperactivity disorder.

2 non-randomised and comparative observational studies;^{51,52} 3 consecutive case series.^{8,53,54} One of the case series was identified from the grey literature⁵⁴ and the other was a qualitative substudy of a trial.⁵³ There were two qualitative studies that each included a case study,^{55,56} and two pure case studies.^{7,57} Two studies included preliminary economic evaluation.^{39,54} The summary findings are reported in Tables DS2 and DS4 and the effect sizes (calculated or reported) are given below.

RCTs

The RCTs examined interventions that fell into four broad types.

- Preparing patients or professionals for their expected role in a therapy before they received a therapeutic intervention.^{40,42,46,49,50}
- Enhancing and adapting existing therapies in terms of technical content and attention to cultural beliefs and idioms of distress.^{39,41,43,44,48}
- Influencing wider social systems (community agencies, family, social networks) before and during therapy.^{39,47}
- Ethnic matching of the professional and patient by the use of telepsychiatry.⁴⁵

Outcomes

Symptoms of anxiety, depression or psychosis were assessed in 8 of the 11 trials.^{39,41–45,47,48} Other outcomes were insight,⁴¹ impairment,⁴² functioning,^{39,47} adherence,^{41,45–49} patient experience,³⁹ perceived helpfulness,⁴⁶ patient satisfaction,^{45,49} knowledge and attitude towards treatment⁴⁰ and perceived stigma.⁴⁶ One study included working alliance as an outcome,⁴⁵ otherwise, the relationship between the intervention and improved therapeutic communications were inferred and not direct measures of therapeutic communication.

High-quality trials

A study of African and Black Caribbean patients with depression and anxiety, compared treatment as usual with flexible outreach from psychiatric services into community venues to encourage use of cognitive-behavioural therapy (CBT). The CBT was supplemented with ethnically matched therapists alongside advocacy, mentoring and rapid access. The intervention led to reductions in the General Health Questionnaire (GHQ-28) scores 3 months after the intervention (calculated effect size $d = -0.69$, 95% CI -1.31 to 0.11 , in favour of treatment; mean difference of reduction from baseline, unadjusted 4.19 , 95% CI -2.19 to 10.5 , $P = 0.49$; adjusted for age, past psychiatric history and baseline score 7.76 , 95% CI 0.86 to 14.65 , $P = 0.03$).³⁹ There were also gains

Table 1 Quality scores, given as percentages of maximum score possible

Study design and authors	Does intervention improve therapeutic communication?	Outcome as a measure of therapeutic communication	Ethnic groups	Quality of design	Economic evaluation	Total score
Randomised controlled trials (score range), percentage of maximum	(1–4)	(1–3)	(0–5)	(0–30)	(0–4)	(0–46)
Rathod <i>et al</i> (2013) ⁴¹	75	66.67	100	67.13	0	80.43
Acosta (1983) ⁴⁰	75	66.67	40	40	0	41.3
Afuwape <i>et al</i> (2010) ³⁹	100	66.67	100	56.67	75	67.39
Alvidrez <i>et al</i> (2009) ⁴⁶	75	66.67	20	50	0	45.65
Chong & Moreno (2012) ⁴⁵	50	100	20	53.33	0	47.83
Grote <i>et al</i> (2009) ⁴⁷	75	66.67	20	46.67	0	43.48
Kanter <i>et al</i> (2010) ⁴⁸	50	33.33	0	40	0	32.61
Hinton <i>et al</i> (2004) ⁴⁴	75	66.67	60	53.33	0	52.17
Hinton <i>et al</i> (2005) ⁴³	75	66.67	60	70	0	63.04
Lambert & Lambert (1984) ⁴⁹	50	66.67	0	26.67	0	26.09
Tom (1989) ⁵⁰	50	66.67	20	70	0	56.52
Wissow <i>et al</i> (2008) ⁴²	75	66.67	20	83.33	0	67.39
Quantitative studies (score range), percentage of maximum	(1–4)	(1–3)	(0–5)	(0–34)		(0–46)
Alvidrez <i>et al</i> (2005) ⁵²	75	66.67	20	26.47		32.61
Kohn <i>et al</i> (2002) ⁵¹	75	66.67	60	29.65		19.57
Case series (score range), percentage of maximum	(1–4)	(1–3)	(0–5)	(0–38)		(0–50)
Kirmayer <i>et al</i> (2003) ⁸	75	33.33	0	60.53		54
Palinski <i>et al</i> (2011) ⁵⁴	100	100	100	86.84		90
Chow <i>et al</i> (2010) ⁵³	75	66.67	20	78.95		72
Case studies and qualitative (score range), percentage of maximum	(1–4)	(1–3)	(0–5)	(0–87)		(0–99)
Bhui & Bhugra (2004) ⁷	75	33.33	100	63.22		64.65
Chu <i>et al</i> (2012) ⁵⁵	50	33.33	60	77.01		73.74
Schouler Ocas <i>et al</i> (2008) ⁵⁷	50	33.33	60	50.57		50.51
Grote <i>et al</i> (2007) ⁵⁶	75	66.67	20	52.87		52.53
Chow <i>et al</i> (2010) ⁵³	75	66.67	20	64.37		72.73

for the Short form (SF-12) mental component measure (adjusted mean difference -11.93 , 95% CI -21.99 to -1.88 , $P=0.02$).

Compared with usual treatment, Rathod *et al* showed that culturally adapted CBT reduced symptoms (on the Comprehensive Psychopathological Ratings Scale) for Black British, African Caribbean and South Asian Muslim patients with schizophrenia (post-treatment calculated effect size $d=-0.18$, 95% CI -0.94 to 0.58 ; 6 months follow-up, calculated effect size $d=0.15$, 95% CI -0.57 to 0.86 ; unadjusted mean difference of reduction from baseline 11.31 , 95% CI 0.14 to 22.49 , $P=0.05$; adjusted mean difference from baseline 9.53 , 95% CI 1.85 to 20.91 , $P=0.01$).⁴¹ At 6 months follow-up, benefit was only seen for depressive symptoms (mean difference of reduction from baseline interval 5.26 , 95% CI 2.92 to 7.60 , $P<0.001$; adjusted mean difference of reduction from baseline 4.24 , 95% CI -0.44 to 8.94 , $P=0.07$).

Wissow *et al* trained paediatric professionals during three 1 h discussions using video examples of family/provider communication, followed by practise and self-evaluation.⁴² They recruited Black, Latin-American and other ethnicities in the USA. Parental symptoms on the GHQ diminished in the intervention group (reported effect size $d=(1.7/5.4)=0.31$, mean difference -1.7 , 95% CI -0.32 to -0.11) and children from minority ethnic groups had less impairment at 6-month follow-up (score reduction of Strengths and Difficulties Questionnaire (SDQ) by 0.91 , 95% CI -1.8 to -0.01 , $P=0.05$). In subgroup analysis this was sustained only for Black children (mean difference SDQ score -1.1 , 95% CI -2.0 to -0.24 ; effect size $d=(1.1/2.5)=0.44$).

Medium-quality trials

There were two RCTs of culturally adapted CBT compared with treatment as usual, for treatment-resistant post-traumatic stress

disorder (PTSD) and panic attacks in Vietnamese and Cambodian refugees in the USA.^{43,44} Adapted CBT led to significantly fewer anxiety symptoms at the end of the treatment of Vietnamese and Cambodian refugees (Anxiety Sensitivity Index, $d=-4.3$, 95% CI -6.32 to -2.22 , and -3.78 , 95% CI -4.82 to 2.75 , respectively). Improvement was also noted for post-traumatic symptoms measured on the Harvard Trauma Questionnaire (Vietnamese patients: calculated $d=-2.4$, 95% CI -3.88 to -0.92), the Clinician Administered PTSD severity scale (Cambodian patients: calculated $d=-2.17$, 95% CI -2.95 to -1.39), and on the Hopkins Symptoms Checklist anxiety subscale (Vietnamese patients: calculated $d=-2.21$, 95% CI -3.64 to -0.77) and depression subscale (Vietnamese patients: calculated $d=-1.99$, 95% CI -3.38 to -0.61). Anxiety and depression symptoms improved for Cambodians on the Symptom Checklist-90 scale (calculated $d=-2.8$, 95% CI -3.68 to -1.94). The original paper did not present confidence intervals, nor effect sizes for follow-up assessments that showed less difference and sometimes no differences. Culturally shaped symptoms of headache and panic also improved.

A randomised pilot study of a multicomponent intervention screened for depression in African American and White pregnant women in antenatal services.⁴⁷ The intervention elements were motivational and ethnographic interviewing to empower women to seek access to interpersonal therapy for depression.⁴⁷ These methods of clinical assessment allowed patients' cultures, identity and shared priorities to be the focus of engagement before offering therapy, choices and information. Those receiving the intervention had less severe depressive symptoms at 3 and 6 months after the baseline (Beck Depression Inventory (BDI): reported effect size of treatment and time interaction: Cohen's $d=0.33$ and 0.47 , respectively; Edinburgh Postnatal Depression screening

tool: Cohen's $h = 0.71$ and 0.89 , respectively; Beck Anxiety Inventory Cohen's $d = 0.27$ and 0.24 , respectively; and on an outcome of 'no longer met diagnostic criteria for depression': Cohen's $h = 0.96$ and 1.22 , respectively; social and leisure functions: 0.26 and 0.46 , respectively; confidence intervals not reported, and Cohen's h calculated from χ^2).

A pilot randomised trial of a psychoeducational leaflet for older African Americans who were referred to out-patient psychotherapy had no effect on symptoms, attendance or stigma.⁴⁶ Those with high perceived need and those with the most uncertainty about treatment had lower levels of stigma following the intervention. In contrast, those with low perceived treatment need and low uncertainty about treatment had lower stigma scores after receiving the usual information sheet (data not reported to calculate interaction effects).

A study of psychoeducation for Chinese Americans with chronic mental disorders offered some lessons for UK Chinese populations.⁵⁰ This randomised study showed improved knowledge (calculated $d = 0.83$, 95% CI -0.01 to 1.66) about 'Western concepts' of mental disorder, treatment and professional roles following a psychoeducation intervention, but there was no impact on stigma, satisfaction with services or motivation. Younger and more educated people were more likely to show improvements in knowledge.

A pre-therapy trial used audiovisual instructions to prepare low-income, Black, Hispanic and White psychiatric out-patients to enter therapy.⁴⁰ This provided information about generic services. The intervention led to greater knowledge and more positive attitudes about therapy (reported analysis of variance: patient orientation, ethnicity, gender: $F(1,149) = 9.44$, $P < 0.01$; n values not available for calculation of effect sizes).⁴⁰

In a feasibility trial of telepsychiatry, low-income Hispanic patients in primary care were ethnically matched with psychiatrists.⁴⁵ Attendance and symptoms were unaffected, but there were improvements in working alliance (intervention calculated $d = 0.99$, 95% CI 0.63 – 1.36 ; follow-up $d = 1.64$, 95% CI 1.25 – 2.05 ; intervention and follow-up interaction not significant) and in satisfaction (calculated effect size for interaction between follow-up time and intervention: $d = 0.58$, 95% CI 0.23 – 0.93). There was greater adherence with antidepressants ($d = 0.35$, 95% CI 0 – 0.69) but no effect on the number of unproductive days because of depression. More patients using telepsychiatry were willing to pay for care.

Poorer-quality trials

Lambert & Lambert prepared immigrants for a future psychotherapy in treatment centres in Hawaii.⁴⁹ The patients receiving the intervention were more satisfied on several dimensions (for example experiencing change, calculated $d = 1.52$, 95% CI 0.53 – 2.52), recognising therapists' integrity, warmth and respect (calculated $d = 1.01$, 95% CI 0.08 – 1.95), attended a greater proportion of the total number of sessions offered (calculated $d = 1.07$, 95% CI 0.26 – 1.88) and dropping out less often (calculated $d = 0.75$, 95% CI 0.01 – 1.49).

Kanter *et al* conducted a pilot trial of a culturally and linguistically adapted version of CBT, and instigated behaviour change as a driver of emotional change (called behavioural activation) for Latin-American patients attending a bilingual clinic in USA. The intervention was to be applied during the course of the therapy.⁴⁸ There was a significant decrease of depression severity (BDI and Hamilton Rating Scale for Depression; reported $d = 1.07$, $d = 1.43$, respectively).

Non-randomised designs

The outcome measures used in the non-randomised designs included a mixture of standardised instruments, evaluation

questionnaires, evaluative statements and narrative findings (online Tables DS3 and DS4 shows the samples and designs; Table DS5 shows the intervention components).

Of two non-randomised and comparative observational studies,^{51,52} one involved enhancing CBT by improving the terminology and the manual content to address religion, identity, relationships and family values of African American women who were on low incomes and with depression.⁵¹ This produced a mean reduction of 12.5 points on the BDI for the adapted CBT group compared with 5.9 points for the usual unadapted CBT comparison group (no standard deviations were presented, so effect sizes were not calculated). The second non-randomised and comparative observational study included an intervention for older African American medical patients that aimed to promote adherence to a psychotherapy treatment through the use of peer-based psychoeducation before therapy.⁵² When compared with a historical comparison group, no differences were seen in the total number or the proportion of total number of sessions that were attended following intervention. And if two historical controls were removed as they had attended therapy in a previous year, there was a significant effect on the mean number of sessions attended ($d = 0.8$, 95% CI 0.30 – 1.30).

Three studies of consecutive patients examined peer-based family psychoeducation in Chinese and Tamil patients recruited from an assertive outreach team,⁵³ and referrals from in-patient and out-patient community psychiatric services to specialist cultural consultation services (one in Canada and one in the UK) in order to elicit illness narratives to aid decision-making.^{8,54} The family intervention led to more accepting attitudes towards patients (mean after 76.3 (s.d. = 14.72); mean before 64.2 (s.d. = 13.9), $P = 0.01$), and trends towards less stress and perceived burden alongside better mental health. The two cultural consultation studies were exploratory and demonstrated gains in knowledge and changes in clinical management for patients but no change in patient-reported outcomes (Table DS4).

There were two case studies of successful cultural adaptation of treatment. One reported enhancements of existing therapies in terms of content and attention to beliefs for trauma symptoms among Turkish patients;⁵⁷ and the other assessed culturally determined health beliefs (explanatory models) in Bangladeshi patients.⁷

There were two qualitative studies that also included evaluative single case studies. Grote *et al* assessed an evolving model of ethnographic and motivational interviewing using qualitative interviews with African American women with a low-income. This showed positive findings, but the main evaluation was in the form of a single case study,⁵⁶ which was then used to inform a trial that is also reported in this review.⁴⁷ Chu *et al* included qualitative focus groups to iteratively adapt problem-solving therapy for older Chinese adults, and this was proposed to be of value using a single case study.⁵⁵

Thematic analysis of interventions

The components of effective interventions were identified and contrasted across the studies using thematic analysis (Table 2). These also help to understand the elements of cultural adaptations, which were similar across randomised and non-randomised studies. Effective interventions in general included efforts to outreach to the wider community and social systems beyond hospital settings; an important aim of effective interventions was to engage or empower by increasing professional understanding of patients' belief systems about illness, either through formal training or through adapting the content and/or structure of treatment to accommodate ethnic and cultural difference. Compared with non-randomised studies, randomised studies were more likely to

Table 2 Components of interventions emerging from thematic analysis

Study design and authors	Patient			Patient and professional			Adaptation of therapy				Engages		
	Causal explanations	Beliefs	Pre-therapy preparation	Accessibility	Training	Ethnic group specific	Matching	Interview structure and content	Modify content of materials	Adapt technical delivery/structure of therapy		Social systems	Empowers
Randomised controlled trials													
Rathod <i>et al</i> (2013) ⁴¹	◆	◆		◆	◆				◆				◆
Wissow <i>et al</i> (2008) ⁴²					◆	◆							
Afuwape <i>et al</i> (2010) ³⁹		◆		◆	◆	◆	◆				◆	◆	◆
Hinton <i>et al</i> (2005) ⁴³	◆	◆							◆	◆			◆
Hinton <i>et al</i> (2004) ⁴⁴	◆	◆							◆	◆			◆
Chong & Moreno (2012) ⁴⁵					◆								
Alvidrez <i>et al</i> (2009) ⁴⁶			◆					◆	◆	◆	◆	◆	◆
Grote <i>et al</i> (2009) ⁴⁷	◆	◆	◆	◆									◆
Acosta (1983) ⁴⁰			◆	◆		◆							◆
Kanter <i>et al</i> (2010) ⁴⁸			◆										◆
Lambert & Lambert (1984) ⁴⁹		◆	◆	◆		◆	◆						◆
Tom (1989) ⁵⁰		◆		◆		◆	◆						◆
Other designs													
Kohn <i>et al</i> (2002) ⁵¹	◆	◆				◆			◆	◆			
Alvidrez <i>et al</i> (2005) ⁵²			◆			◆			◆				◆
Chow <i>et al</i> (2010) ⁵³	◆	◆	◆			◆			◆				◆
Kirmayer <i>et al</i> (2003) ⁸	◆	◆								◆	◆	◆	◆
Palinski <i>et al</i> (2011) ⁵⁴	◆	◆			◆			◆		◆	◆	◆	◆
Chu <i>et al</i> (2012) ⁵⁵	◆	◆							◆				◆
Grote <i>et al</i> (2007) ⁵⁶	◆	◆		◆		◆				◆	◆	◆	◆
Bhui & Bhugra (2004) ⁷	◆	◆				◆					◆	◆	◆
Schouler Oak <i>et al</i> (2008) ⁵⁷	◆	◆				◆							◆

target multiple ethnic groups (2/10 and 5/12 respectively) and to focus on accessibility of treatment for patients (1/10 v. 4/12).

Patient and carer views

There was less support for approaches that provided 'briefing' or training in 'how to be a patient' (online Table DS5). Somewhat unexpectedly, the use of community workers providing advocacy and stepped-care (the second intervention in online Table DS5), despite attention to practical needs such as entitlement to benefits, was not well regarded. Members of the group felt stepped-care, gradually moving from community to more specialist hospital services, was overcomplicated and might lead to problems in communication between different professionals.

Discussion

This review identified several types of effective interventions evaluated in trials, including adapted cognitive-behavioural treatments,^{41,43,44} adapted psychotherapies more generally,^{39,47,48} complex interventions that engage with social systems (such as community groups) and stepped-care,³⁹ interviewing techniques such as ethnographic and motivational interviewing,⁴⁷ behavioural activation within an adapted cognitive-behavioural paradigm,⁴⁸ information and training for patients to make best use of their services and better use of encounters with professionals,^{40,49} and a telepsychiatry intervention.⁴⁵

Adapted CBT

Adapted CBT for several ethnic groups⁴¹ worked as well as CBT adapted for a single ethnic group.⁴⁴ Patients and carers reviewing the evidence were supportive of these interventions. Importantly, the methods of adaptation paid attention to technical, theoretical, philosophical and practical aspects.²⁵ These adapted interventions were promising as they showed benefit in terms of both symptoms and patient-reported outcomes, and were evolved by including culturally embedded styles of communications about distress within the CBT manual.

Complex interventions

Two trials evaluated complex interventions. Grote *et al* used ethnographic and motivational interviewing to empower pregnant African American single women with depression.⁴⁷ One of the key components of this intervention was the emphasis on empowerment through an understanding of personal stories before offering specialist interventions. This was similar to another complex intervention (Afuwape *et al*)³⁹ offering a stepped-care model of engaging in social venues and then offering an adapted CBT intervention for Black African, Black Caribbean and Black British people living in South London. Both of these were effective at reducing symptoms, yet a consultative panel of patients and carers favoured the USA intervention, because of its emphasis on personal stories and empowering interviews, rather than a stepped-care to access CBT. The stepped-care approach was perceived to be too difficult to negotiate because several professionals at different stages of care risked a failure of communication between them.⁵⁸

Training, education, communications skills

There was one study of a specialist psychiatric service that provided outreach into paediatric services.⁴² This led to less impairment in Black compared with White children and fewer parental symptoms overall. Of the two other trials that included an educational intervention, both included preparing patients for psychotherapy by education using written and audiovisual

materials.^{40,49} The first of these, a poor-quality study, was associated with higher premature drop-out, but more satisfaction in the intervention group and improvements in their expectations of what therapy might offer. The second, a medium-quality study, informed patients' about psychotherapy and improved attitudes so they expected more from therapy. Although less favoured by patients and carers, these preparatory interventions seem attractive to practitioners as a way of enhancing the benefit of existing interventions rather than developing new ones.

Despite the body of literature on cultural competence of professionals as a key way of improving health outcomes and communication between BME patients and professionals,²¹ none of the trials that entered the review tested a specific model of cultural competence. Cultural competence is a concept with a broad framework, so there were examples of interventions that fell under this rubric but differed in their elements and proposed mechanism. Future research might select specific components of interventions from those listed in Table 2, and test them either individually or in combinations. The list might also be valuable to assess against new interventions, and understand potential mechanisms of effect.

One randomised study of telepsychiatry where both patients and psychiatrists were from Hispanic minority groups living in the USA,⁴⁵ showed greater adherence to antidepressants, and improved the working alliance and satisfaction compared with the treatment as usual group. Patients were willing to pay more for this intervention, which suggests its convenience was valued, but the relative benefits of ethnic matching and a telepsychiatry intervention were not disentangled. Telepsychiatry can facilitate provision of services to geographically remote or scattered populations in need of professionals with a similar ethnic background and language skills. In contrast to this study, many studies of ethnic matching are often observational and show an association between ethnic matching and outcomes in administrative data-sets rather than testing an intervention in a trial.^{59,60} The wider issue of using e-technology and social media in order to engage and deliver interventions was not investigated in the studies that entered the review. There is an emerging evidence base on e-interventions for mental health promotion and the treatment of mental illnesses, in remote and varied populations who may be hard to reach, and across age groups.^{61–65} More RCTs are needed among ethnic minorities and culturally diverse populations.

Other study designs

The non-randomised studies assessed psychoeducation, ways of adapting psychotherapies, including a family-oriented intervention, ethnographic interviewing and case studies concerning ethnographic principles. Given that these interventions were at an earlier stage of development, it is reasonable to suggest that their components, especially their ethnographic elements, may prove suitable for testing in trials.^{7,8,34,56,57} Two of these studies showed how to involve the community as a resource to help adapt interventions.^{53,55} Many excluded papers presented accounts of the cultural formulation (as described in the DSM-IV,⁶⁶ and now in modified form in DSM-5⁶⁷), and its use as part of the formal psychiatric assessment process, yet none evaluated the cultural formulation, or offered a sufficiently critical evaluative component for these studies to enter the review.^{68,69}

Intervention elements

Many elements of the interventions were not dissimilar when the trials and non-randomised designs were compared (see online Tables DS1 and DS3). The patient and carer rankings of interventions was instructive, in that these added an additional source of valuable information to the synthesis, alongside the

evidence with respect to effectiveness, and methodological strengths and weaknesses of each study. Their opinions were by no means unanimous but still shed light on which interventions might not suit all patients and why. To some extent the patient and carer perspectives also combated the academically focused research questions and setting. Patients and carers emphasised the personal experience and journey, giving a clear indication that the way professionals communicate and interact are as important as the intervention itself. Therefore, the interventions that encouraged understanding of patient beliefs and causal explanations about illness may not always lead to a direct symptomatic benefit, but nonetheless seem to be important in a recovery-oriented approach. In particular, ethnography, motivational interviewing, engaging with social systems, before and during therapy, and professional-centred interventions seem to warrant further research of their impact on positive professional–patient communication.

Strengths and weaknesses

The remit of this systematic review was specific, namely communications between professionals in psychiatric services and BME-origin patients using these services. However, the findings included multiple interventions with diverse outcomes, and diverse study design.

The effect of improved therapeutic communication was evaluated by assessing various outcomes such as symptoms and adherence. The quality scores were a helpful summary of a complex set of strengths and weaknesses, each of which was taken into consideration alongside the views of the patients and carers in drawing our overall conclusions. The majority of studies assessed entry into psychotherapy interventions rather than routine psychiatric care.

Only four studies were from the UK.^{7,39,41,54} The remaining 17 were from the USA, suggesting more research is needed in the UK and other countries within and outwith Europe. The review found only two studies offering weak economic evidence based on health and social care costs over a 3-month follow-up period.^{39,54} Palinksi *et al* published more detailed costs of accident and emergency attendance, and consultations with nurses and doctors.⁵⁴ Both studies can be described as exploratory rather than definitive, partly because of their small sample sizes, short follow-up periods, and recruitment from a single locality, but both studies offer encouraging economic evidence. There is a need for more economic research.

In conclusion, culturally adapted psychotherapies and ethnographic and motivational assessment leading to psychotherapy were effective and preferred by patients and carers. Further trials are needed from outside of the UK and USA, including studies of routine psychiatric practices, economic evaluations and some testing of the effectiveness of specific elements of interventions that were identified.

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References

- 1 National Institute for Mental Health in England. *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England*. NIMHE, 2003.
- 2 Department of Health. *Delivering Race Equality in Mental Health Care. An Action Plan for Reform Inside and Outside Services and the Government's Response to the Independent Inquiry into the Death of David Bennett*. Department of Health, 2005.
- 3 Bansal N, Bhopal R, Netto G, Lyons D, Steiner MF, Sashidharan SP. Disparate patterns of hospitalisation reflect unmet needs and persistent ethnic inequalities in mental health care: the Scottish health and ethnicity linkage study. *Ethn Health* 2014; **19**: 217–39.
- 4 Cooper C, Spiers N, Livingston G, Jenkins R, Meltzer H, Brugha T, et al. Ethnic inequalities in the use of health services for common mental disorders in England. *Soc Psychiatry Psychiatr Epidemiol* 2013; **48**: 685–92.
- 5 Mangalore R, Knapp M. Income-related inequalities in common mental disorders among ethnic minorities in England. *Soc Psychiatry Psychiatr Epidemiol* 2012; **47**: 351–9.
- 6 Priebe S, Richardson M, Cooney M, Adedeji O, McCabe R. Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychother Psychosom* 2011; **80**: 70–7.
- 7 Bhui K, Bhugra D. Communication with patients from other cultures: the place of explanatory models. *Adv Psychiatr Treat* 2004; **10**: 474–8.
- 8 Kirmayer LJ, Groleau D, Guzder J, Blake C, Jarvis E. Cultural consultation: a model of mental health service for multicultural societies. *Can J Psychiatry* 2003; **48**: 145–53.
- 9 Szczepura A. Access to health care for ethnic minority populations. *Postgrad Med J* 2005; **81**: 141–7.
- 10 Johnson MRD, Clark MD, Owen D, Szczepura A. *The Unavoidable Costs of Ethnicity: A Review of Evidence on Health Costs*. Centre for Health Services Studies, University of Warwick, 1999.
- 11 McCabe R, Priebe S. Explanatory models of illness in schizophrenia: comparison of four ethnic groups. *Br J Psychiatry* 2004; **185**: 25–30.
- 12 Shioiri T, Someya T, Helmeste D, Tang SW. Cultural difference in recognition of facial emotional expression: contrast between Japanese and American raters. *Psychiatry Clin Neurosci* 1999; **53**: 629–33.
- 13 Shioiri T, Someya T, Helmeste D, Tang SW. Misinterpretation of facial expression: a cross-cultural study. *Psychiatry Clin Neurosci* 1999; **53**: 45–50.
- 14 Elfenbein HA, Ambady N. On the universality and cultural specificity of emotion recognition: a meta-analysis. *Psychol Bull* 2002; **128**: 203–35.
- 15 Elfenbein HA, Ambady N. When familiarity breeds accuracy: cultural exposure and facial emotion recognition. *J Personality Soc Psychol* 2003; **85**: 276–90.
- 16 Elfenbein HA, Mandal MK, Ambady N, Harizuka S, Kumar S. Cross-cultural patterns in emotion recognition: highlighting design and analytical techniques. *Emotion* 2002; **2**: 75–84.
- 17 Tesone JE. Multi-lingualism, word-presentations, thing-presentations and psychic reality. *Int J Psychoanal* 1996; **77**: 871–81.
- 18 Rudell K, Bhui K, Priebe S. Concept, development and application of a new mixed method assessment of cultural variations in illness perceptions: Barts Explanatory Model Inventory. *J Health Psychol* 2009; **14**: 336–47.
- 19 Bhui K, Bhugra D, Goldberg D. Causal explanations of distress and general practitioners' assessments of common mental disorder among Punjabi and English attendees. *Soc Psychiatry Psychiatr Epidemiol* 2002; **37**: 38–45.
- 20 Bennett J KJ, Keating F. *Race Equality Training in Mental Health Services in England. Does One Size Fit All?* Sainsbury Centre for Mental Health, 2011.
- 21 Bhui K, Warfa N, Edonya P, McKenzie K, Bhugra D. Cultural competence in mental health care: a review of model evaluations. *BMC Health Serv Res* 2007; **7**: 15.
- 22 Kleinman A. *Patients and Healers in the Context of Culture*. University of California Press, 1980.

- 23 Smithbattle L, Lorenz R, Leander S. Listening with care: using narrative methods to cultivate nurses' responsive relationships in a home visiting intervention with teen mothers. *Nurs Inq* 2013; **20**: 188–98.
- 24 Chowdhary N, Jotheeswaran AT, Nadkarni A, Hollon SD, King M, Jordans MJ, et al. The methods and outcomes of cultural adaptations of psychological treatments for depressive disorders: a systematic review. *Psychol Med* 2014; **44**: 1131–46.
- 25 Tseng W. *Handbook of Cultural Psychiatry*. Academic Press, 2001.
- 26 Bhui K, McCabe R, Weich S, Singh S, Johnson M, Szczepura A. THERACOM: a systematic review of the evidence base for interventions to improve therapeutic communications between black and minority ethnic populations and staff in specialist mental health services. *Syst Rev* 2013; **2**: 15.
- 27 Cambridge J, Singh SP, Johnson M. The need for measurable standards in mental health interpreting: a neglected area. *Psychiatrist* 2012; **36**: 121–4.
- 28 Liu J, Davidson E, Bhopal R, White M, Johnson M, Netto G, et al. Adapting health promotion interventions to meet the needs of ethnic minority groups: mixed-methods evidence synthesis. *Health Technol Assess* 2012; **16**: 1.
- 29 Anderson LM, Scrimshaw SC, Fullilove MT, Fielding JE, Normand J. Culturally competent healthcare systems. A systematic review. *Am J Prev Med* 2003; **24** (suppl 3): 68–79.
- 30 Szczepura A, Clark MD, Johnson MRD, Owen D. *Assessment of the Costs to the NHS Arising from the Need for Interpreter, Advocacy and Translation Services. Resource Allocation Series RARP*. University of Warwick, 1999.
- 31 Bhui K, Stansfeld S, Hull S, Priebe S, Mole F, Feder G. Ethnic variations in pathways to and use of specialist mental health services in the UK: systematic review. *Br J Psychiatry* 2003; **182**: 105–16.
- 32 Moncrieff J, Drummond DC. The quality of alcohol treatment research: an examination of influential controlled trials and development of a quality rating system. *Addiction* 1998; **93**: 811–23.
- 33 Deeks J, Dinnes J, D'Amico R, Sowden A, Sakaravitch C, Song F, et al. Evaluating non-randomised intervention studies. *Health Technol Assess* 2003; **7**: 1–192.
- 34 Reisch JS, Tyson JE, Mize SG. Aid to the evaluation of therapeutic studies. *Pediatrics* 1989; **84**: 815–27.
- 35 Moga C, Guo B, Schopflocher D, Harstall C. *Development of a Quality Appraisal Tool for Case Series Studies Using a Modified Delphi Technique*. Institute of Health Economics, 2012.
- 36 Spencer L, Ritchie J, Lewis J, Dillon L. *Quality in Qualitative Evaluation: A framework for assessing research evidence. A Quality Framework*. The Cabinet Office, 2003.
- 37 Concato J, Shah N, Horwitz RI. Randomized, controlled trials, observational studies, and the hierarchy of research designs. *New Engl J Med* 2000; **342**: 1887–92.
- 38 Popay J, Roberts H, Sowden A, Petticrew M, Arai A, Rodgers R, et al. *Guidance on the Conduct of Narrative Synthesis in Systematic Reviews*. NCSR, Institute for Health Research, 2006.
- 39 Afuwape SA, Craig TK, Harris T, Clarke M, Flood A, Olajide D, et al. The Cares of Life Project (CoLP): an exploratory randomised controlled trial of a community-based intervention for black people with common mental disorder. *J Affect Disord* 2010; **127**: 370–4.
- 40 Acosta F. Preparing low-income hispanic, black, and white patients for psychotherapy. *J Clin Psychol* 1983; **39**: 872–7.
- 41 Rathod S, Phiri P, Harris S, Underwood C, Thagadur M, Padmanabi U, et al. Cognitive behaviour therapy for psychosis can be adapted for minority ethnic groups: a randomised controlled trial. *Schizophr Res* 2013; **143**: 319–26.
- 42 Wissow LS, Gadowski A, Roter D, Larson S, Brown J, Zachary C, et al. Improving child and parent mental health in primary care: a cluster-randomized trial of communication skills training. *Pediatrics* 2008; **121**: 266–75.
- 43 Hinton DE, Chhean D, Pich V, Safren SA, Hofmann SG, Pollack MH. A randomized controlled trial of cognitive-behavior therapy for Cambodian refugees with treatment-resistant PTSD and panic attacks: a cross-over design. *J Trauma Stress* 2005; **18**: 617–29.
- 44 Hinton DE, Pham T, Tran M, Safren SA, Otto MW, Pollack MH. CBT for Vietnamese refugees with treatment-resistant PTSD and panic attacks: a pilot study. *J Trauma Stress* 2004; **17**: 429–33.
- 45 Chong J, Moreno F. Feasibility and acceptability of clinic-based telepsychiatry for low-income Hispanic primary care patients. *Telemed J e-Health* 2012; **18**: 297–304.
- 46 Alvidrez J, Snowden LR, Rao SM, Boccellari A. Psychoeducation to address stigma in black adults referred for mental health treatment: a randomized pilot study. *Community Ment Health J* 2009; **45**: 127–36.
- 47 Grote NK, Swartz HA, Geibel SL, Zuckoff A, Houck PR, Frank E. A randomized controlled trial of culturally relevant, brief interpersonal psychotherapy for perinatal depression. *Psychiatr Serv* 2009; **60**: 313–21.
- 48 Kanter JW, Santiago-Rivera AL, Rusch LC, Busch AM, West P. Initial outcomes of a culturally adapted behavioral activation for Latinas diagnosed with depression at a community clinic. *Behav Modif* 2010; **34**: 120–44.
- 49 Lambert R, Lambert M. The effects of role preparation for psychotherapy on immigrant clients seeking mental health services in Hawaii. *J Community Psychol* 1984; **12**: 263–75.
- 50 Tom LM. *Psychoeducational Approach with Chronically Mentally Ill Chinese Americans: A Cultural Adaption Framework*. The City University of New York, 1989.
- 51 Kohn LP, Oden T, Muñoz RF, Robinson A, Leavitt D. Adapted cognitive behavioral group therapy for depressed low-income African American women. *Community Ment Health J* 2002; **38**: 497–504.
- 52 Alvidrez J, Areal P, Stewart A. Psychoeducation to increase psychotherapy entry for older African Americans. *Am J Geriatr Psychiatry* 2005; **13**: 554–61.
- 53 Chow W, Law S, Andermann L, Yang J, Leszcz M, Wong J, et al. Multi-family psycho-education group for assertive community treatment clients and families of culturally diverse background: a pilot study. *Community Ment Health J* 2010; **46**: 364–71.
- 54 Palinski A, Owiti JA, Ascoli M, De Jongh B, Archer J, Staples P, et al. *A Cultural Consultation Service in East London: Experiences and Outcomes from Implementation of an Innovative Service*. Queen Mary University of London, 2012.
- 55 Chu JP, Huynh L, Areal P. Cultural adaptation of evidence-based practice utilizing an iterative stakeholder process and theoretical framework: problem solving therapy for Chinese older adults. *Int J Geriatr Psychiatry* 2012; **27**: 97–106.
- 56 Grote N, Zuckoff A, Swartz H, Blesdoe SE, Geibel S. Engaging women who are depressed and economically disadvantaged in mental health treatment. *Social Work* 2007; **52**: 295–308.
- 57 Schouler-Ocak M, Reiske SL, Rapp MA, Heinz A. Cultural factors in the diagnosis and treatment of traumatised migrant patients from Turkey. *Transcult Psychiatry* 2008; **45**: 652–70.
- 58 Franx G, Oud M, de Lange J, Wensing M, Grol R. Implementing a stepped-care approach in primary care: results of a qualitative study. *Implement Sci* 2012; **7**: 8.
- 59 Cabral RR, Smith TB. Racial/ethnic matching of clients and therapists in mental health services: a meta-analytic review of preferences, perceptions, and outcomes. *J Couns Psychol* 2011; **58**: 537–54.
- 60 Maramba GG, Hall GC. Meta-analyses of ethnic match as a predictor of dropout, utilization, and level of functioning. *Cultur Divers Ethnic Minor Psychol* 2002; **8**: 290–7.
- 61 Lillevoll KR, Vangberg HC, Griffiths KM, Waterloo K, Eisemann MR. Uptake and adherence of a self-directed internet-based mental health intervention with tailored e-mail reminders in senior high schools in Norway. *BMC Psychiatry* 2014; **14**: 14.
- 62 Ruggiero KJ, Resnick HS, Acierio R, Coffey SF, Carpenter MJ, Ruscio AM, et al. Internet-based intervention for mental health and substance use problems in disaster-affected populations: a pilot feasibility study. *Behav Ther* 2006; **37**: 190–205.
- 63 Livingston JD, Cianfrone M, Korf-Uzan K, Coniglio C. Another time point, a different story: one year effects of a social media intervention on the attitudes of young people towards mental health issues. *Soc Psychiatry Psychiatr Epidemiol* 2014; **49**: 985–90.
- 64 Woolderink M, Smit F, van der Zanden R, Beecham J, Knapp M, Paulus A, et al. Design of an internet-based health economic evaluation of a preventive group-intervention for children of parents with mental illness or substance use disorders. *BMC Public Health* 2010; **10**: 470.
- 65 Blankers M, Nabitz U, Smit F, Koeter MW, Schippers GM. Economic evaluation of internet-based interventions for harmful alcohol use alongside a pragmatic randomized controlled trial. *J Med Internet Res* 2012; **14**: e134.
- 66 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder (4th edn) (DSM-IV)*. APA, 1994.
- 67 American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorder (5th edn) (DSM-5)*. APA, 2013.
- 68 Baarnhielm S. The meaning of pain: a cultural formulation of a Syrian woman in Sweden. *Transcult Psychiatry* 2012; **49**: 105–20.
- 69 Fortuna LR, Porche MV, Alegria M. A qualitative study of clinicians' use of the cultural formulation model in assessing posttraumatic stress disorder. *Transcult Psychiatry* 2009; **46**: 429–50.

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Online supplement DS1

Inclusion and exclusion criteria

Inclusion criteria

Studies that report evaluations of:

1. Models of therapeutic communication designed to improve assessment, diagnosis, clinical decision-making, treatment and treatment adherence for black and minority ethnicity patients
2. Other aspects of direct communication, e.g. consensual/participatory activities, including participatory aspects of cultural consultation, conflict resolution, cultural competence, consent issues, complaints and grievances, drawing up care plans and crisis plans
3. Tele-consultation services (e.g. NHS Direct, telemedicine, e-mail consultations, etc.).
4. Psychiatric care which involved outreach or referral into services
5. Service user interventions if they assisted with therapeutic communications in specialist mental health care

Exclusion criteria

1. Articles that simply report on translation or interpreter use in clinical assessment
2. Studies of services for populations speaking diverse languages
3. Studies that implemented a construct of therapeutic communication without adapting it to local needs or conditions
4. Evaluations of actual therapeutic communications (e.g. psychological therapies) rather than interventions that might improve therapeutic communications
5. Articles in which ethnic minorities or ethnicity were 'mentioned in passing' and were not a significant focus
6. Evaluations with no specific focus on interventions to improve therapeutic communication with patients receiving psychiatric care
7. During the review we also decided to exclude alcohol-related treatments and treatments for drug misuse, as separate evidence reviews for these had been undertaken previously, and the nature of the interventions and the settings would not match our inclusion criteria
8. The interventions were for the management of chronic diseases or behaviours associated with mental distress or disorder, rather than the mental distress or disorder itself, such as attention-deficit hyperactivity disorder (ADHD) or HIV, or smoking cessation
9. Where no intervention was evaluated, but analysis of routine data led to an inference that modifiable characteristics were those that showed an association with a measure of therapeutic communication; for example, ethnic matching as a derived variable in routine data were not included, whereas studies prospectively matching on an ethnic (or other) characteristic and testing the impact on the outcome were eligible for entry

Online supplement DS2

Search strategy and sources

Published literature

These terms were applied from the earliest possible date to 4 April 2012 and re-run January and February 2013.

The following databases were searched: MEDLINE, PsycInfo, Embase, ASSIA (applied social science index), Cochrane database of systematic reviews, Campbell Collaboration, ACP Journal Club, Cochrane Central Register of Controlled Trials, Cochrane Methodology Register, Allied and Complementary Medicine, CINAHL, British Nursing Index, Health Management Information Consortium, Social Science Citation Index, SocialCareOnline and NHS Evidence collection on ethnicity and health.

Economic papers

A series of systematic Medline searches was undertaken by the information scientist to identify economic materials that were potentially relevant to interventions. All other sources were also assessed for economic elements to the identified sources.

Hand Searches

Hand searches of the following journals were completed for the study period April 2007 to May 2012: *Transcultural Psychiatry*; *Culture, Medicine and Psychiatry*; *International Journal of Social Psychiatry*; *Journal of Cross-Cultural Psychology*; *Ethnicity and Health*; *Ethnicity and Disease*; and *Diversity in Health & Care*. In addition, two special issues of journals were also screened: *Psychotherapy: Theory, Research, Practice, Training*, special issue *Culture, Race, and Ethnicity in Psychotherapy*, Volume 43(4), 377–560, winter 2006; *Journal of Counselling Psychology*, Volume 58(4), 457–646, October 2011.

Recent journals and collections

We used a variety of strategies: ‘hand-searching’ more recent issues of journals on ethnicity and health (those that had appeared in the past 10 years), and journals on communications; ‘cascade-searching’; and searching specialist collections at the Centre for Evidence in Ethnicity, Health and Diversity (CEEHD), King’s Fund, NHS library on ethnicity and health, HTA, NICE, Royal College of Psychiatrists and Medical Foundation for the Care of Victims of Torture. We also made use of various web-based sources (e.g. Google, NHS Evidence, JISCmail) to search for reports that were not published in conventional research or professional journals and ‘research in progress’.

Theses

We searched all dissertations and theses accepted for higher degrees by universities in Europe and North America up to February 2013. Conference papers were identified through key term searches of the ProQuest Conference Papers Index from June 2004 to February 2013.

Websites

Websites were searched systematically using key terms. Two further electronic sources were examined; *NHS Evidence* and *JiscMail Archive*. Websites of research funding bodies were searched to identify projects in progress or those that had been completed. The following sites were included: Clinical Research Network (UKCRN) Study Portfolio, NIHR Evaluation, Trials and Studies Coordinating Centre (NETSCC), MRC and ESRC websites.

Experts

Experts were invited to comment on omissions in the searches and to put forward candidate papers and to volunteer research work that was unpublished or in progress. We consulted with experts known to the research group and/or to the service users. Community groups and charities were also contacted to identify materials in community-based collections. An online questionnaire (www.surveymonkey.com/s/TheracomSurvey) was developed and a personal invitation sent to 37 experts in the field and to 75 organisations for circulation to their members. A reminder was sent to all non-responders after two weeks. Finally, a request was posted on the 'Minority-Ethnic-Health' Jiscmail discussion group.

Online supplement DS3

Quality scoring schema

Core criteria

- (1) the clarity with which the intervention was described as improving therapeutic communication directly or by inference or not at all (scoring 1-4)
- (2) whether the outcomes of therapeutic communication were directly measured using a reliable and valid scale (scores 1-3)
- (3) whether the ethnic groups was described in a manner consistent with a specific classification scheme for ethnicity (not just 'race'; scores 0-5). Core criteria scores ranged from 2 to 12 (scores of zero on the intervention to improve therapeutic communications and on outcome would have lead to exclusion of the study, so studies had to score at least 2 to enter the review.

Specialised for specific study design

For *randomised controlled trials*, used Moncrieff & Drummond's schema.³² Fifteen items score 0, 1, or 2 (range 0–30).

For the quality assessment of *case-control or cohort studies*, we consulted an HTA evaluation of non-randomised observational studies.³³ From the recommended scales, we selected that created by Reisch *et al*³⁴ as it considers important confounding factors and differences between groups prior to the intervention; it has a good case-mix adjustment; and it is a validated numeric scale (scores 0–34). We adopted the scoring system developed by the Canadian Institute of Health Economics (IHE).³⁵ We added a scoring system to the checklist; hence, a 'yes' to a criterion in the checklist would qualify for a score of 1, and 'no' would score 0 (scores range from 0 to 38).

For *case studies, qualitative studies and studies from the grey literature*, we chose the NATCEN quality assessment criteria that score methodological and conceptual quality. We allocated a mark for each question asked and each of the items that might be endorsed to indicate quality, and so the scale offers a range of 0 to 87.³⁶

Economic studies were separately scored. These were rated 1–4 on the basis of the type of economic analysis. Cost-effectiveness studies scored 4, impact of interventions and cost–benefit studies scored 3, an intervention being costed scored 1, or the benefits being considered in terms of finances, scored 1. A zero was scored if there was no economic evaluation.

Table DS1: Characteristics of Trials

First Author & Date	Sample Size and Ethnic Groups	Country	Intervention	Study Design
Rathod, 2013	African Caribbean: CaCBTp = 5 vs TAU = 4 Black African: 1 vs 4; Mixed race: 4 vs 6; Pakistani: 3 vs 3; Bangladesh: 2 vs 0; Other (Iranian): 1 vs 0	UK	Culturally adapted CBT for psychosis (CaCBTp). Guided by Tseng's framework of philosophical, practical, technical and theoretical adaptation.	RCT in two centres. 35 participants with a diagnosis from schizophrenia group of disorders. CaCBTp participants were offered 16 sessions of CaCBTp with a trained therapists and compared with standard treatment.
Wissow, 2008	418 children 54% white 30% black 12% Latino 4% other ethnicities. .	USA	Brief communication training of three, one-hour discussions using video examples of family/provider communication. Each was followed by practice with standardised patients and self-evaluation. Skills encouraged were of eliciting parent and child concerns, partnering with families, and increasing expectations that treatment would help. Psychiatrists training primary care professionals to work with family, negotiate treatment choice and expectations of treatment.	Cluster randomised RCT. The training was tested with providers at 13 sites. Children (5–16 years of age) on a routine visit were enrolled if they screened “possible” or “probable” for mental disorders on a questionnaire, or if their provider said they were likely to have an emotional or behavioural problem.
Afuwape, 2010	40 black African origin (black African individuals born in sub-Saharan Africa or born in the UK with at least one parent of sub-Saharan descent) and of black Caribbean origin (black patients born in the Caribbean or born in the UK with at least one parent of Caribbean descent).	UK	Needs led stepped-care approach by 6 community health workers with a more experienced therapists. Practical advice, assistance, advocacy for social needs, health education, mentoring, brief therapies base on CBT and brief work focused on solutions. CBT with ethnically matched therapists (Black African and Black Caribbean origin), delivered through multiple social sites with significant flexibility.	RCT: Individuals were randomised to a needs-led package of care (‘rapid access’) or to a 3-month waiting list control with information on local mental health services (‘standard access’). The needs-led package involved practical advice and assistance, advocacy for social needs, health education and mentoring as well as one-to-one brief therapies based on principles of cognitive behavioural therapy and brief solution by ethnically matched therapists; ‘rapid access’)

Hinton, 2005	Cambodian refugees (n=40) 20 patients in the initial treatment (IT) and 20 in delayed treatment (DT).	USA	Culturally adapted CBT for Cambodian refugees with treatment-resistant posttraumatic stress disorder (PTSD) and panic disorder (PD). Information about PTSD and PD, muscle relaxation and diaphragmatic breathing, culturally appropriate visualisation, relaxation techniques/mindfulness; cognitive restructuring of fear networks; exposure to anxiety-related sensation alongside re-association to positive images to treat panic attacks generated by sensation-activated fear networks. Exposure to and narrativisation of trauma-related memories. Teaching cognitive flexibility, practice set shifting, during the emotional-processing protocol: shifting from acknowledgment of trauma to self and other pity, to kindness and to mindfulness.	RCT: Individual CBT was offered across 12 weekly sessions. Cambodian bicultural workers and a clinician fluent in Cambodian delivered assessment and treatment.
Hinton, 2004	(n=12) non-English speaking Vietnamese refugees.	USA	Culturally adapted cognitive-behaviour therapy for Vietnamese refugees with treatment-resistant posttraumatic stress disorder (PTSD) and panic disorder (PD). Eight core elements highlighted in the sessions: providing information about the nature of PTSD and PD. (As for Hinton 2005).	Pilot of RCT: Individual CBT was offered across 11 weekly sessions. The lead author delivered the CBT while Vietnamese social workers and staff provided translation and cultural consultation.
Chong, 2012	80 intervention and 89 TAU Hispanic patients	USA	Tele-psychiatry intervention for Hispanic patients. Online meeting programme between Hispanic psychiatrists and Hispanic low-income primary care patients seeking consultation. Two Hispanic psychiatrists fluent in English and Spanish; organisational readiness concept; importance of mental health treatment accepted; payment not expected of either group. Patient and psychiatrists sit in front of respective PC using webcam.	RCT: Eligible subjects were randomly assigned to tele-psychiatry using Webcam (WEB) or treatment as usual (TAU). Those assigned to the WEB condition agreed to arrive for tele-psychiatry sessions once a month for 6 months (1 h for intake and six 30-min follow-ups). Those assigned to the TAU were told that their provider would be responsible for their mental health needs.
Alvidrez - 2009	42 clients self identified as Black/African Americans, first time clients of the clinic.	USA	<i>Getting Mental Health Treatment: Advice from People Who've Been There</i> was a psychoeducation booklet developed from qualitative interviews revealing Black patients' experiences with mental health treatment and stigma; included information on what consumers wished they had before entering mental health treatment, challenges faced getting or staying in treatment, strategies to deal with challenges, and advice on making treatment work better.	RCT: Comparison with information in two existing brochure on local mental health services, and the services in the outpatient clinic. 22 of 42 assigned to psychoeducation and 20 to general information.

Grote 2009 (pilot data reported in 2007 and included in this paper).	53 non-treatment seeking pregnant African American women (n=33) and white counterparts (n=20).	USA	Short enhanced culturally relevant interpersonal therapy. Brief Interpersonal Psychotherapy (IPT-B) delivered as part of multicomponent care for antenatal depression. Engagement sessions were followed by 8 Brief Interpersonal Psychotherapy sessions before the birth and maintenance IPT up to six months postpartum. IPT was combined with motivational and ethnographic interviews taking account of social isolation, vulnerability and financial strain.	RCT: Fifty-three non-treatment seeking, pregnant African-American and white patients receiving prenatal services were randomly assigned to receive either enhanced IPT-B (N=25) or enhanced usual care (N=28). Participants were assessed before and after treatment.
Acosta - 1983	N = 173 62 Hispanic, 51 black, 60 white	USA	Audio-visual programme instructing patients about psychotherapy. Orientation, role induction, management of expectations assuming knowledge is limiting factor. An audio-visual slide/cassette program titled 'Tell It Like It Is' designed to inform patients from widely diverse ethnic, language, and cultural backgrounds about verbal psychotherapy. Combined simple explanations of the therapy process with presentations of vignettes that model helpful patient behaviours such as self-disclosures and direct statements of patient expectations.	RCT: Patients in each of the three ethnic groups were assigned randomly to one of two experimental groups, (a) oriented; and b) not oriented. The study employed a 2 x 3 x 2 factorial design, with two levels of patient orientation (oriented and not oriented). Three levels of patient ethnicity (Hispanic, black, and white) and two levels of patient sex (male and female). The control patients saw a programme that was neutral with regard to psychotherapy
Kanter 2010	Total - 10 Latino clients. Country of origin: 60% Mexico, 30% Puerto Rico, 10% United States.	US	Behavioural activation therapy adapted for Latino patients (BAL for short). More practical rather than psychological. Language matching in some cases. Adaptations account for the clients' circumstances, and sensitivity to the support resources, including the local community, spiritual traditions, and the extended family; specification of culturally sensitive activation targets, incorporation of Latino-specific cultural values and beliefs, addition of specific strategies to address treatment engagement and retention in the first session.	RCT: 10 people randomly assigned to BAL, 12 to a control condition.

Lambert & Lambert 1984	Matching not expected to improve potency, but if it took place would work against finding significant effects. Ethnic background decided on the basis of 11-item questionnaire. n = 30.	USA	Role induction involved role preparation interview to inform and manage expectations, clarify client and therapist roles, provide rational basis for patient to accept therapy to deal with problems, provide a general outline for the course of therapy with particular emphasis on the clarification of hostile and negative feelings; and convey information designed to create 'more positive and realistic' attitudes.	RCT: 30 immigrant clients were assigned to either role induction (therapy preparation intervention) or a placebo intervention prior to receiving therapy.
Tom , LM 1989	Chinese-Americans: 12 in experimental and 12 in continuing treatment group.	USA	Formation and application of a culturally relevant psychoeducation programme. Incorporated relevant cultural issues including Chinese perceptions of illness, concepts and terms. A lecture format was used with slide show and hand-outs, followed by a question and answer period. Topics included the disparity between Chinese and American views on mental disorders, the major diagnostic categories of mental disorders, symptoms of psychosis, the purpose of medication in treatment, warning signals of relapse, modalities and settings for treatment and roles of mental health professionals.	RCT & Post-test Control Group Design 30 Chinese-American clients were assigned to psychoeducation or a regularly scheduled group. 24 participated in the trial. On trial completion, control group clients were given the option to receive the intervention.

Table DS2: Findings from trials

Study	Outcome Measures	Narrative Summary
Rathod, 2013 Wissow, 2008	Primary outcome: Comprehensive Psychopathological Rating Scale (CPRS) Several subscales were derived and analysed: The Montgomery–Asberg Depression Rating Scale (MADRAS), The Schizophrenia Change Rating Scale (SCS), Brief Rating Instrument for Assessment of Negative Symptoms Scale (BRAINS). Secondary outcome: Insight in Psychosis scale, Patient Experience Questionnaire (PEQ), Medication	CaCBTp was acceptable and effective as evidenced by a significant reduction of symptomology on CPRS total and subscales scores post treatment. The only gains maintained at follow-up were in the MADRAS subscale, although a positive trend towards reduction was noted overall. A sub analysis from the study revealed change in domains two and three (acceptance of illness and re-labelling of psychotic symptoms) as statistically significant when adjusted for baseline scores. The CaCBTp group engaged well when judged by attrition rates, mean number of sessions attended and the scores on the PEQ questionnaire. Overall satisfaction was associated with accessibility, type of therapy, therapist and involvement in decision-making process. The CaCBTp group presented with a significantly higher rate of medication change than the TAU group at the six month follow up.
	Parent Mental Health Symptoms-rated on GHQ28. Child Symptoms and Functional Impairment-computed total symptom (range: 0–40) and impairment (range: 0–10) scores from the parent-rated SDQ.	Minority children (black and Latino combined) seeing trained providers had a decrease in impairment compared with white children. For black children, seeing a trained provider was associated with a significantly greater decrease in impairment compared with children seeing control providers. For Latino children, there was a trend toward greater reduction in impairment among those seeing a trained provider.
Afuwape, 2010	Primary outcome: At 3 months, GHQ-28 total scores. Secondary outcome: transformed sub-scales of the GHQ-28; Physical Functioning, Role-Physical, Bodily Pain, General Health, Vitality, Social Functioning, Role Emotional, Mental Health, Experience of a severe difficulty from the Life Events and Difficulty. General psychosocial functioning using the GAF; 8 transformed scales of the SF-36 and the Mental and Physical component summary scores; ‘fresh start’ events and cost of service use.	Training was associated with a significantly greater decrease in parent symptom across ethnicities, compared with seeing a control provider. Seeing a trained provider was associated with a significant decrease in symptoms for the parents of children with an enrolment SDQ rating indicating the possibility of having a mental disorder but not for parents of children rated as probable or unlikely to have a mental disorder. Access to a needs-led package of care significantly improved mental health among black individuals with depression and anxiety with limited additional cost implications. There was a significant decrease in depression for the rapid access group compared to the control group and positive trends in outcomes for anxiety and insomnia for the rapid assessment group compared to the control group. Fresh start events were significantly associated with symptom improvement. These results were achieved with a study sample consisting of individuals with moderately severe levels of untreated mental illness despite most having contact with some form of NHS service in 3 months prior to baseline.

Hinton, 2005	<p>1. Anxiety Sensitivity Index (ASI) 2. Clinician-Administered 3. PTSD Scale (CAPS) 4. Neck Panic Attack Severity Scale (N-PASS) and 5. Orthostatic Panic Attack Severity Scale (O-PASS) 6. Neck-Panic Flashback Severity Scale (N-FSS) and 7. Orthostatic-Panic Flashback Severity Scale (O-FSS) 8. Symptom Checklist-90-R (SCL) Scales 9. PTSD Status 10. GAD Status. Completed at four time points: (a) pre-treatment (first assessment), (b) after the IT Group had undergone 12 sessions of CBT (second assessment), (c) after the DT Group had undergone 12 sessions of CBT (third assessment), and (d) for both groups, 12 weeks after the completion of therapy (follow-up assessment). At 4-week intervals, the severity of neck- and orthostatic-associated panic (N-PASS and O-PASS), as well as neck- and orthostatic-panic-associated flashbacks (N-FSS and O-FSS) were assessment, starting 4 weeks prior to the IT Group's treatment and continuing until completion of the DT Group's treatment.</p>	<p>Culturally adapted CBT targeting PTSD and comorbid panic attacks for traumatised Cambodian refugees was well accepted and efficacious. This was evidenced by a significant reduction in PTSD and GAD symptomology post intervention. Observed improvements may have been influenced by a 'therapist effect' rather than a 'treatment effect' as the same therapist provided all treatment.</p>
Hinton, 2004	<p>1. The Harvard Trauma Questionnaire (HTQ), translated and validated for the Vietnamese population, 2. The Hopkins Symptom Checklist-25 (HSCL-25), translated and validated for the Vietnamese population, 3. Anxiety Sensitivity Index (ASI), translated and validated for the Vietnamese population 4. The Headache Panic Attack Severity Scale (HPASS) 5. Orthostatic Panic Attack Severity Scale OPASS) Outcomes from HTQ, HSCL-25 and ASI were measured (a) at pre-treatment (first assessment); (b) after Group 1 had undergone 11 sessions of CBT (second assessment); and (c) after Group 2 had undergone 11 sessions of CBT (third assessment). Outcomes from HPASS and OPASS were measured every two weeks 1. The Headache Panic Attack Severity Scale (HPASS) 2. Orthostatic Panic Attack Severity Scale (OPASS) .</p>	<p>Culturally adapted CBT targeting PTSD and comorbid panic attacks for traumatised Vietnamese refugees was well accepted and efficacious. This was evidenced by a significant reduction in PTSD and GAD symptomology post intervention. Observed improvements may have been influenced by a 'therapist effect' rather than a 'treatment effect' as the same therapist provided all treatment.</p> <p>It was not possible to determine whether this combined treatment as opposed to other treatments would be more efficacious as this was a small powered study.</p>
Chong, 2012	<p>1. The Personal Health Questionnaire 9 (PHQ-9), WEB - each session (for six months); TAU - baseline, 3 and 6 months, post-baseline. 2. The Mini International Neuropsychiatric Interview (MINI) - only once for exclusion and inclusion. 3. The Acculturation Rating Scale for Mexican Americans (ARSMA II) 4. Sheehan's Disability Scale (SDS) Patients baseline and 3 and 6 months post-baseline. WEB - monthly. TAU - baseline and 3 and 6 months 5. Visit Specific Satisfaction</p>	<p>Working alliance and visit satisfaction rated as higher for WEB than TAU. More WEB patients used antidepressants. While there was no difference in overall depression score, WEB depression scores improved at a faster rate than TAU. Twice as many web patients were willing to pay more for tele-psychiatry. WEB patients wanted longer sessions, reporting 30 mins as too short, and TAU patients wanted more sessions.</p>

	<p>Questionnaire (VSQ-9) was developed from Rand's Medical Outcomes Study. The VSQ-9 was found to reflect patient–doctor communication if used immediately after the clinical visit. 6. Working Alliance Inventory Short Form rate questions regarding the working relationship between them and the clinician/therapist during the specific clinic visit. It measures three subscales of the alliance that are related to the goal, task, and client–therapist bond. VSQ-9 (doctor patient communication) satisfaction ratings, proportion of completed primary care appointments.</p>	
Alvidrez - 2009	<p>Symptom severity based on Global Severity Score of Brief Symptom Inventory. Perceived need for treatment. Treatment concerns. Diagnosis. Stigma-discrimination (devaluation-discrimination scale). Helpfulness of information (questionnaire). Treatment entry and attendance.</p>	<p>Interactions revealed that individuals perceiving themselves to have a greater treatment need, and individuals expressing more uncertainty about treatment, had greater stigma reduction if they received psychoeducation. Individuals with lesser perceived treatment need, and individuals with less uncertainty about treatment, showed greater stigma reduction if they received general information not psychoeducation.</p>
Grote 2009	<p>Baseline, three months later, six months post partum: depression diagnoses, symptoms. EPNDP for screening in, Beck 21 item for depression diagnosis if cut off >10; Beck 21 anxiety measure; social functioning on Social Adjustment Scale's social and leisure domain.</p>	<p>Treatment adherence patients in the IPT-B group showed significantly higher rates of treatment engagement and retention than patients in the usual care group;. Intention-to-treat analyses showed that participants in enhanced IPT-B, compared with those in enhanced usual care, displayed significant reductions in depressive symptoms before childbirth (three months post-baseline) and at six months postpartum and showed significant improvements in social functioning at six months postpartum.</p>
Acosta - 1983	<p>Attitude Toward Psychotherapy; questionnaire is an 8-item questionnaire on 6-point Likert-type scales that ranged from "agree strongly" to "disagree strongly". Knowledge Questionnaire, 10 items with multiple-choice questions.</p>	<p>The orientation program was successful in increasing a patient's information about psychotherapy and a patient's role in that process.</p> <p>While there were no interactions between ethnicity and the orientation main effect, across the groups knowledge of psychotherapy was found to be related to ethnicity with white patients scoring as most knowledgeable, followed by Hispanic and then Black patients.</p> <p>Oriented patients were significantly more positive towards psychotherapy than non-oriented patients. More specifically, oriented patients indicated that they were more willing to make self-disclosures and to discuss problems with their therapists, more willing to be assertive in telling the therapist when they disagreed with him/her, more willing to be direct with the therapist with regard to how many sessions they were willing to attend, and more accepting</p>

Kanter 2010	17-item HSRD, a Spanish-speaking version; Spanish BDI-ii, Spanish PRIME-MD. Pan-Hispanic familialism scale, short acculturation scale, multidimensional acculturative stress inventory, and a treatment adherence checklist.	of the concept that talking about problems would be helpful to them. BAL did well with respect to treatment adherence, engagement and retention. BAL was effective in decreasing depression severity evidenced by a significant decrease in symptoms for both completers and intent to treat groups on BD-II and HRSD scales.
Lambert & Lambert 1984	<p>Patient admission form, background information - client; background information - therapist; revised client expectancy inventory, approval seeking, advice seeking; audience-seeking; relationship seeking; psychotherapy questionnaire - Therapy Evaluation Inventory; premature termination; attendance rate measured by the number of scheduled sessions a client failed to attend from the time of his assignment to a therapist through the sixth therapy session.</p> <p>Knowledge of mental illness and treatment using modified Knowledge about Schizophrenia Questionnaire. Attitude towards mental illness using. modified Opinions about mental illness Instrument Satisfaction with services using Client Satisfaction Questionnaire Motivation for treatment using staff completed modified Task Check List Questionnaires were administered in a group setting. Oral administration in order to minimise the number of unanswered items</p>	<p>Role preparation intervention has impact for high-risk clients like immigrants. There was a reduction in premature termination for the experimental participants (EP) group compared to the control participants (CP) group. EP reported greater satisfaction and perceived change in self. The EP group as compared to the CP group saw therapists as more interested, respectful, and accepting.</p> <p>Both groups had entered treatment expecting unrealistically high levels of rational guidance, structure and direction, to have difficulty with verbalising, difficulty in spontaneous self-disclosure, and with developing an egalitarian relationship. In comparison to the CP group, the EP group significantly improved their expectancy scores in relation to advice seeking, audience seeking, and relationship seeking.</p>
Tom, LM 1989		The psychoeducation enhances knowledge of western concepts of mental illness and treatment methods. The experimental group had a greater years of education than the control group, potentially contributing to their higher mean score on KSQ. In the experimental group, individuals who were younger, better educated, or had a longer duration of illness were most knowledgeable about concepts of mental illness and treatment. This suggests that younger more chronic patients with at least a high school level of education would benefit most from psychoeducation.

Table DS3: Characteristics of non-randomised designs

First Author & Date	Sample Size and Ethnic Groups	Country	Study Type	Detail of Intervention
Kohn, 2002	20 African American women. 10 in AACBT group. Comparator 10, demographically matched women who had been treated with CBT. Approximately 83% of these patients (10/12) opted for treatment in the AACBT group. One woman preferred individual to group treatment; another preferred the CBT group. Of 10 African American women who agreed to enter the AACBT , 8 completed therapy and were compared to ten women who were demographically matched on race, age, education, income, diagnosis, referral source, women who had been previously treated in the CBT group.	US	Observational Studies	Culturally adapted cognitive behavioural group therapy for depressed African American women. The CBT consists of three four-session cognitive behavioural modules. After completing each of the three modules patients repeat the first module for a total of 16 sessions. These modules focus on cognitions, activities, and relationship; based on cognitive behavioural treatment for depression. Structural adaptations include limiting the group to African American women, any age, with a diagnosis of Major Depressive Disorder; keeping the group closed to facilitate cohesion; adding experiential meditative exercises during treatment and a termination ritual at the end of the 16-week intervention and; changes in some of the language used to describe cognitive-behavioural techniques. For example, rather than using the term “homework” the group members were asked for suggestions and agreed upon a preferred term “therapeutic exercises.” Whenever possible, African American individuals and anecdotes from African American literature were used as examples to illustrate concepts. Didactic adaptations of materials: creating healthy relationships; spirituality; African American family issues; African American female identity. These adaptations represent our attempt to contextualise the therapy manual to address issues relevant to African American women in treatment for depression.

Alvidrez, 2005	<p>All African American. 32 patients recruited to intervention, 37 in the historical control group. Thirty-one participants (97%) completed follow-up interviews. Historical comparison group of 37. The 32 participants did not differ significantly from the 12 patients who were not enrolled in the study. 31 completed follow-up interviews. The historical-comparison group consisted of a consecutive sample of African American patients referred to on-site clinic psychologists for psychotherapy in the 12-month period before study initiation. From a total of 39 African American patients identified, 2 already enrolled in the current study were excluded, resulting in a final comparison group sample of 37.</p>	USA	Observational study	<p>Descriptive pre and post comparison. Historical comparison (historical-control group). The psychoeducation script begins with a brief description of psychotherapy and specific services offered; then six topics: the concerns identified in the focus groups: how a medical-model of psychiatric disorders reduces stigma; illnesses leading to involuntary hospitalisation; the importance of the patient's input in therapy goals and topics; the importance of talking about conflicts, misunderstandings, or dissatisfaction with treatment; differences between therapists and patients and how these can be helpful; receptivity of therapists to discuss religion/spirituality and incorporating into treatment. In the psychoeducation session, the psychoeducator read from the script while the participant followed along with a large-print handout summarising the major points. The session was didactic; participants were encouraged to ask questions and raise concerns about treatment. Psychoeducation intervention is a 15-minute, scripted individual session. Content developed by 22 participants in 3 focus groups, discussing barriers to mental health treatment for older African Americans. Barriers included stigma of receiving, mental health services; fear of hospitalisation or institutionalisation; reluctance to work with a non-African American therapist; feeling pressure to divulge personal information or discuss irrelevant material; the lack of attention to religious beliefs/spirituality by therapists; and dissatisfaction when the therapist does not provide solutions.</p>
Chow, 2010	<p>7 Chinese clients with mean age (sd) of 38.6 (6.5), 2 women (29%). Mean age (sd) of 11 Chinese family members of 64.3 (11.6), 7 women (64%). There were 7 Tamil clients with mean age (sd) of 37.6 (6.4), 1 woman (14%). 9 Tamil family members with mean age (sd) of 55.1 (17.9), with 6 women (67%).</p>	Canada	Case series	<p>Psychosocial conference at a local restaurant to introduce the study, then transport provided to attend MFPG; meeting held at preferred community venues; meetings at weekends following by lunch. 2-hour session once a month for 12 months .2 sessions to listening to concerns around medication and chronic disease needing medication. Provider and client stakeholder input with iterative testing process within a FMAP (formative method for adapting psychotherapies) to create problem-solving therapy for older Chinese clients. The use of community venues, transport, and engagement to recruit to the study are part of the adaptation. 2-hour</p>

				<p>sessions, once a month for 12 months. 2 sessions listening to concerns around medication and chronic disease needing medication. Cultural adaptation using evidence based practice using an interactive stakeholder process and theoretical framework: problem-solving therapy for Chinese older adults. Focus groups and interviews with community providers and a depressed 60 year old Chinese elder to assess feasibility of modification to PST; community providers included 31 para-professionals, or doctoral or masters level clinicians or trainees. Focus groups and interviews 1.5-2 hours each.</p>
Kirmayer - 2003	<p>Descriptive pre/post assessments in a case series with some case studies.</p> <p>Evaluation data: 100 cases, 27% Canadians, 24% immigrants, 41% asylum seekers and refugees. 50 ethnocultural groups (undifferentiated). Four cases involved requests from organisations to discuss issues related to their work with a whole ethnocultural group or community.</p>	Canada	Case series	<p>Cultural consultation of referred patients. Cultural consultation: three types of activity 1) consultant with relevant cultural expertise assessed the patient, preferably with the participation of the referring person. 1-3 meetings with patient, brief written report, phone call or case conference.</p>
Palinski, A., Owiti, J., et al	<p>46 depth consultations. White British 15%, White other 4%, Asian or Asian British Pakistani 4%, Asian or Asian British Bangladeshi 40%, Other Asian background 2%, Black or Black British Caribbean 4%, Black or Black British African 9%, Black or Black British Somali 15%, Mixed White and Black Caribbean 2%, Other Ethnic Background 18%.</p>	UK	Case Series	<p>Cultural consultation model adapted to elicit narratives from service users, carers, staff, and organisational managers. These reconciled to support clinical decisions for patient care. Adapted from Kirmayer 2003, to include the organisational narratives and team narratives and staff narratives. Specialist CCS staff worked alongside existing staff rather than take referrals. Provided a report and advice on management based on documentary analysis, narrative information, and participant and non-participant observations.</p>

Chu, 2012	Case study, participant recruited from primary care setting. Single Chinese older woman to test intervention.	USA	Qualitative	An iterative stake-holder and client input process, the FMAP (formative method for adapting psychotherapies), to adapt Problem Solving Therapy for treatment of depression in Chinese older adults and create the Problem Solving Therapy for Chinese Older Adults (PST-COA) manual. Provider and client stakeholder input using participatory approach, then integrating stakeholder input with literature review, then refining the intervention using an iterative testing process within a FMAP (formative method for adapting psychotherapies) to create problem solving therapy for older Chinese clients.
Chow, 2010	As above for case series Chow 2010	Canada	Qualitative	Psychosocial conference at a local restaurant to introduce the study, then transport provided to attend MFPG; meetings held at preferred community venues; meetings at weekends following by lunch. 2 hour session once a month for 12 months Each session led by a supervisor supported by two group facilitators who spoke the participants' language. 2 sessions were dedicated to listening to concerns around medication and chronic disease needing medication. 10 sessions followed a slightly modified MFPG model.
Grote 2007 (pilot trial data reported in Grote 2009)	A 33 year old unmarried African American woman who lived with her 7 year old son and her physically disabled unemployed boyfriend. Is the primary breadwinner in the family, working at night at a low-wage job in the inventory department of a large store. At the initial intake interview, she was diagnosed with moderately severe level of depressive symptoms on the Beck Depression Inventory. 28 weeks pregnant when she came to the engagement interview.	USA	Case Study	Enhanced Culturally Relevant, Brief Interpersonal Psychotherapy (IPT-B) is a multicomponent model of care designed to treat antenatal depression and consists of an engagement session, followed by eight Brief Interpersonal Psychotherapy sessions before the birth and maintenance IPT up to six months postpartum. Engagement interview includes ethnographic interviewing and motivational interviewing. Ethnography empowers, elicits narrative of patient and experience and meaning-making, and negotiates the treatment, taking account of social systems and resources in the community. The intervention changes the type of interview, in order to improve engagement and better inform the discussion about treatment. Elicit story, treatment interest and hopes, feedback and psychoeducation, eliciting commitment.

Bhui, K - 2004	Psychiatrist and two patients in mental health services in UK	UK	Case Study	2 case histories. Negotiating explanatory models to aid in assessment, and also to facilitate delivery of CBT including a negotiated agreement, but not adapting the CBT content.
Schouler-Ocak 2008	Outpatient trauma clinic	Germany	Case Study	Clinical ethnography to influence decision-making. Transference based psychotherapy but trauma focused, informed by cultural perspectives on coping, an understanding of religious perspectives.

Table DS4 Findings from non-randomised designs

First Author & Date	Main findings
Kohn, 2002	<p>The intervention was acceptable and effective. Women in the culturally adapted (AACBT) group exhibited alleviation of twice the magnitude of women in the usual (CBT) treatment group. Both groups' scores suggested a need for further treatment. In Nietzel's meta-analysis, with a predominantly White, middle class population (n = 28 studies), the post-treatment BDI score was 12; in Organista's outcome study (1994), with a predominantly low-income, public sector population (n = 70), the post-treatment BDI score was 18.0. For low-income, African American women, the post-treatment score was 21.8 in the AACBT condition (n = 8) and 24.4 in the regular CBT condition (n = 10). This suggests that CBT for depression may work best in the population for which it was developed, and becomes less effective as groups differ.</p>
Alvidrez, 2005	<p>An equal proportion (75%) of patients in each group started therapy. Therapy entry and attendance, in the 3- month period after the psycho-education session: 24 of the 32 study participants (75%) attended at least one psychotherapy session (range 1 to 10). Therapy entry was not related to an African American psycho-educator (71%) or not (76%; p=0.8), nor were there significant differences in the number of sessions attended (mean: 3.3, SD: 2.9 vs 4.2, 1.9; Mann-Whitney U 36.0; exact p=0.45).</p> <p>In the historical-comparison group, 28 of the 37 (76%) attended at least one session (range: 1 to 8). In the 3-month period after referral, the proportion of participants who attended at least one session did not differ by intervention status.</p> <p>Psycho-education participants who started therapy attended significantly more sessions. In the follow-up interviews, 25 of the 31 participants reported attending at least 1 psychotherapy session in the 3-month period after the psycho-education session. The majority of participants (84%) found the psycho-education very or somewhat helpful. Just over half (52%) of those who began therapy said that the psycho-education influenced their decision to begin therapy "a great deal." When 6 who did not begin therapy were asked if the psycho-education influenced their decision, all said no except one who reported that the psycho-education influenced her decision "somewhat". 29 of 31 respondents (94%) said ethnicity of psycho-educator made no difference to perceived helpfulness. One respondent who had an African American psycho-educator said the session was more helpful and another who had a non-African American psycho-educator said the session was less helpful because of the ethnicity of the psycho-educator. Experience in therapy: among the 24 patients starting therapy, 60% said the psycho-education addressed many or all of their concerns about treatment. Helpfulness for on-going therapy issues: a majority indicated at least slight helpfulness in all areas. The strongest ratings were given for the role of psycho-education in helping the patient to bring up concerns about treatment and discussing ethnic, cultural, or religious issues with the therapist. Although a majority indicated that the psycho-education helped them deal with stigma concerns, this was endorsed less frequently and less strongly than the other topics.</p>
Chow, 2010	<p>Participation: 57% families in study attended at least half of the session. The mean score of family members' acceptance was significantly increased (64.20 ± 13.90 vs. 76.30 ± 14.72, $df = 13$, $p = 0.01$). This acceptance was more pronounced in families, which participated in more than 50% of the sessions (n = 8, 61.38 ± 16.54 vs. 80.05 ± 17.02, $df = 7$, $P = 0.01$). A rank order correlation analysis found that attendance was associated with greater reduction in family burden ($r = 0.5$, $P = 0.05$). No significant changes were found in other SAS variables, but some positive trends were noted: the family members' perceived burden of the client, family members' satisfaction with their own physical health, mental health and health in general.</p>

Kirmayer - 2003	<p>29 referring clinicians (representing 47 cases) completed service evaluation questionnaires. 86% reported that they were satisfied with the consultation and that it had helped them manage their patients. Useful aspects of the consultation included increased knowledge of the social, cultural, or religious aspects of their cases (41%); increased knowledge of the psychiatric or psychological aspects of their cases (21%); improved treatment (48%); improved communication, empathy, understanding, or therapeutic alliance (31%); and increased confidence in diagnosis or treatment (14%). The major difficulties or dissatisfactions with the cultural consultation were the lack of treatment or more intensive follow-up (14%), unavailability or inappropriateness of recommended resources (14%), concerns about the competence of the culture broker (10%), and the impression that there was too much focus on social context, rather than on psychiatric issues (10%). All said they would use the service again and would recommend that their colleagues use it. They reported high rates of concordance with recommendations. In 21 cases, some aspect of the CCS recommendations was not implemented. Reasons for this included patient noncompliance (n =13), lack of staff or other resources (n = 9), and spontaneous improvement (n = 7). Language barriers and cultural complexity prevent adequate diagnosis and treatment for a significant number of patients, including refugees, new immigrants, and members of established ethnocultural communities. A cultural consultation service can respond to these needs in most cases. Assessments, treatment plans, and interventions are well received by referring clinicians. There is a need to train clinicians systematically in the effective use of interpreters, culture brokers, and the cultural formulation.</p>
Palinski, A., Owiti, J., et al	<p>Response rate from clinicians: 78% at baseline and 46% at follow-up. Service users: 61% at baseline and 35% at follow-up. Service level outcomes collected at baseline and follow-up for 36 patients. Clinician-rated clinical outcomes: 36 at baseline and 20 at follow-up. After the cultural consultation process clinicians rated service users as having significantly higher overall functioning compared with ratings before the CCS work, on the Global Assessment of Functioning ($p < 0.02$). No significant changes were found for CANSAS rated needs of service users, nor the clinicians' rating of the therapeutic relationship (measured using the STAR). Non-significant trends include more met needs on the CANSAS and a lower score on the CORE. Quantitative Cultural Competence Assessment: 67 clinicians completed the TACCT questionnaire at baseline and 28 at follow-up. The change between baseline (mean=90.21; sd=19.11) and follow-up (mean=95.4; sd= 18.87) (Mann Whitney U= 635.5; $p < 0.02$) was significant. Service level outcomes (n=36 at baseline and follow-up): the level of service receipt (and associated costs) significantly reduced after CCS intervention, with a significant reduction in use of A&E ($p < 0.02$), psychiatrists baseline ($p < .001$) and CPNs and case managers ($p < .001$). No significant difference in hospital admissions were found, but this was measured over a 3 month period. Referrals were for perplexing and complex clinical presentations, lack of sufficient knowledge or lack of comprehensive understanding about the cases; concerns about racism and discrimination; lack of engagement or progress and failed treatment alliance; exploration, and resolution, of cultural conflicts, and the impact of social changes on service user's recovery; information requests; defensive practices. The focus of interventions was to minimise miscommunication, provide links with third sector and statutory bodies for support; offer and suggest new interventions / assessments; suggest psychological interventions and services with suitable culturally appropriate models; offer education, empowerment, autonomy and choice; family engagement and mediation; diagnostic clarification</p>
Chu, 2012	<p>Themes emerging from stakeholder feedback, literature review, and pilot testing: a need for flexibility; psychoeducation and de-stigmatising language; managing expectations of the provider-client relationship involving attention to hierarchy, respect, case management, and providing suggestions; visual aids and measurement; and incorporation of acculturative processes. The adapted intervention resulted in a decrease in depressive symptoms for the test participant and improved mood. Community providers evaluated the intervention as cultural appropriate and the pilot participant rated the intervention as satisfactory and effective. .</p>
Chow, 2010	<p>Key themes from content analysis from focus group transcripts: reduced stigma and shame, less isolation among family; increase in understanding of client's condition more support from family; reduced helplessness and hopelessness; improvement in client-family relationships; mutual enhancement of MFGP and ACT; importance of cultural and linguistic matching between clients/family and clinicians.</p>

**Grote 2007 (pilot trial
data reported in Grote
2009)**

Patient engaged, motivated, and completed therapy sessions, with improvements in mood, despite social circumstances.

**Bhui, K -
2004**

Patient recovery through partial adoption of understanding patient's explanatory model, leading to a jointly formed treatment plan. Consultations that involve culturally grounded explanatory models of illness challenge the professional. Through case studies, a method of reconciling different explanatory models is evaluated.

**Schouler-Ocak
2008**

The strategies used to deal with symptoms induced by trauma are often culture-specific. There are unique aspects of trauma-focused psychotherapy in patients with a history of migration (trauma focused therapy + explanatory models). Approaches included combining trauma focused therapy including visualisation and reliving experience with massage, physiotherapy, swimming, exercise groups, all used to improve overall wellbeing and develop self-help skills. Religion became important to in one patient's therapy, given its role in preventing suicide, so religious prescriptions were encouraged.

Table DS5: Patient and Carer ranking of interventions

Intervention	High priority	Lowest priority	Selected comments by users
Communication training for doctors and patients	◆◆◆		This is the first access point and if this is done right, pathways to appropriate support can follow. Had some trouble understanding this intervention.
Community workers practical advice & advocacy		◆◆	Seems crisis oriented – too many professionals. How serious or unwell does one really have to be before you get to see the more experienced therapist and psychiatrist'?
'Cultural consultation' team assessment	◆◆◆		I think I dislike the phrase 'consultant with cultural expertise'.
'Explanatory models' of mental illness	◆◆◆		This knowing of what is best must arise out of a dialogue between patient and professional, which is respectful, mutually intelligible, culturally sensitive, and open enough to engage with a wide range of explanatory models and ideas for recovery. People are not afraid of what they know: more information is a must.
Telepsychiatry (Skype) to language competent staff"			Telepsychiatry is important for a client who doesn't want to go out or see anyone face to face.
'Role induction' briefing the user first		◆◆	This intervention sounds like marketing therapy to patients Very important to clarify what to expect. Not in a crisis situation though.
Culturally adapting e.g. CBT to specific cultures		◆◆	This still won't work if the people running it are culturally incompetent.
Ethnographic and motivational interviewing	◆◆◆		A way of validating and working empathetically with individuals Very compelling, but is this interventionist 'style' not what most people expect from ALL therapy and all interviews?
'Ethnic matching' of client and service provider		◆◆	Yes, bi-lingual and bi-cultural (and gender) ethnic matching is important, necessary, and helpful for some. But in other cases, it makes no difference, and for others, it is not appropriate because the therapist is culturally too close to the patient. Must resist simplistic assumptions and generalisations. This has helped me: I know it works..
'Multi-Family Psycho-education Group'		◆◆	Allows in-depth work with user/family and chances for identifying with others to create opportunity to build connections. The multi-family education group is not for me because my family believe mental health is a curse. People don't always have families.

◆◆◆ = three or more votes in support. ◆◆ More than one disagreement on the value of the intervention.

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Interventions to improve therapeutic communications between Black and minority ethnic patients and professionals in psychiatric services: systematic review

Kamaldeep S. Bhui, Rabeea'h W. Aslam, Andrea Palinski, Rose McCabe, Mark R. D. Johnson, Scott Weich, Swaran P. Singh, Martin Knapp, Vittoria Ardino and Ala Szczepura
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